POC # 3 Acceptable

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445264	A. BUILDING _____ B. WING _____	09/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUGHLIN HEALTH CARE CENTER	801 E MCKEE ST GREENEVILLE, TN 37743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey and investigation of complaints (#33486, #33831, #34148, #32888) were completed on September 16, 2014, at Laughlin Health Care Center. No deficiencies were cited related to the complaints under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	**Laughlin Healthcare Center acknowledges that during the Recertification Survey and Investigation of Complaints (#33486, #33831, #34148, #32888), completed on September 16, 2014, no deficiencies were cited related to the complaints under 42 CFR Part 483, Requirements for Long Term Care Facilities.**	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to correctly administer two of twenty-five medications during the medication administration observation, resulting in an eight percent medication error rate. The findings included: Medical record review of resident #38's Physician Order Report dated August 16, 2014, revealed "...levalbuterol HCL (Hyrochloride) solution for Nebulization; 1.25 mg (milligram)/3 ml (milliliter)...give per nebulizer (hand held machine that delivers medicine in a fine mist an individual would inhale)...twice a day..." Observation on September 14, 2014, in resident #38's room at 10:05 a.m., revealed Licensed Practical Nurse (LPN) #1 poured the levalbuterol into the nebulizer cup and turned the nebulizer	F 332	**483.25(m)(1) F 332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE** **REQUIREMENT:** The facility must ensure that it is free of medication error rates of five percent or greater. **POC:** 1. LPN #1 was provided in-service education by ADON on 9/26/14 regarding staying with residents during nebulizer treatments. LPN #2 was provided in-service education by ADON on 9/16/14 regarding correct procedure for administering medications. The Medication Errors on affected residents were reported as Medication Errors and given to Medical Director. Resident #38 and Resident #153 were monitored for any adverse reactions related to medication errors, no adverse reactions noted due to medication errors were seen. 2. All Licensed Nurses will be given in-service education by RN Supervisors on correct procedure for administering Continued to page 2 of 5	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

G.B. Administrative Assistant 10/27/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 332	Continued From page 1 machine on. Continued observation revealed LPN #1 handed the hand held nebulizer/cup to the resident and left the room. Continued observation revealed the resident placed the hand held nebulizer in the lap and conversed with a visitor in the room. Continued observation revealed at 10:16 a.m., LPN #1 returned to the room, and the resident placed the hand held nebulizer in the mouth. Continued observation revealed at 10:18 a.m., LPN #1 turned off the nebulizer machine, the resident handed LPN #1 the partially full nebulizer cup, and LPN #1 placed the hand held nebulizer/cup into the holder on the machine and left the room. Interview on September 15, 2014, at 3:05 p.m., with LPN #1, at the East Nurse's desk, confirmed LPN #1 did not stay with the resident during the nebulizer treatment, and resident #38 did not receive the full nebulizer treatment, resulting in a medication error. Medical record review of resident #153's Physician Order report dated August 15, 2014, to September 15, 2014, revealed the resident was to receive a multivitamin with minerals daily. Observation on September 16, 2014, at 9:00 a.m., revealed LPN #2 prepared and administered medications to resident #153. Continued observation revealed LPN #2 poured a multivitamin without minerals into the medication cup, took it to the resident's room and administered the multivitamin without minerals. Interview on September 16, 2014, at 1:20 p.m., with LPN #2, at the West Nurse's desk, confirmed LPN #2 administered a multivitamin without minerals to resident #153, and the physician's	F 332	Continued from page 1 of 5 medications. This will be completed by 10/06/14. All residents receiving nebulizer treatments or receiving medications had potential to be affected. RN Supervisors did random med pass observations and all patients receiving nebulizer treatments were found to have treatments administered appropriately. No problems noted on nebulizer treatment med pass observations. 3. Annual In-Services by DON, ADON, RN Supervisors and/or designee will be given to all Licensed Nurses and all new Licensed Nurses will be mentored and signed off as competent in correct procedure in Medication Administration. 4. The DON, ADON and nurse managers and/or designees will monitor this process in random med pass observations to make sure proper procedure is being followed, weekly times 4 weeks then every month to ensure compliance, and in 90 Day Evaluations and Annual Evaluations. Medication Errors are reviewed in the Monthly QA Meetings. October 06, 2014	

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F 332	Continued From page 2 order was for a multivitamin with minerals, resulting in a medication error.	F 332		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	**483.65 F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS** **REQUIREMENT:** The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it- (1) Investigates, controls, and prevents infections in the facility, (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident, (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. Continued to page 4 of 5	

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F 441	Continued From page 3 infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide appropriate infection control while administering medications for one Licensed Practical Nurse (LPN #1) of three LPNs observed administering medications. The findings included: Observation on September 14, 2014, at 10:00 a.m., of LPN #1 in the hall way near room 136, revealed LPN#1 with the bare hands, touched the computer mouse, the medication cart, the medication cart drawer, and the medication card. Continued observation revealed with the bare hands, LPN #1 then pushed the Xanax pill out of the card into the fingers, placed the pill in the medication cup, picked up a pair of scissors from the medication cart and cut open a package of medications. Continued observation revealed the Potassium Chloride pill was dropped from the package onto the top of the medication cart, LPN #1 picked the pill up with the bare fingers, placed it into the medication cup, took the medications to the resident's room and administered the medications. Interview on September 15, 2014, at 3:05 p.m., at the East Nurse's desk, confirmed LPN #1 touched the computer mouse, the medication cart, the medication cart drawer, and the medication card with the bare hands. Continued interview confirmed LPN #1 then pushed the resident's Xanax out of the package into the bare	F 441	Continued from page 3 of 5 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. **POC:** 1. LPN #1 was in-served by ADON on 9/26/14 on appropriate infection control while administering medications. 2. All Licensed Nurses will be in-serviced by ADON on appropriate infection control while administering medications for other residents that could be affected. Random Medication Pass Observation are being done by RN Supervisors to make sure proper Infection Control procedure is being followed. All residents receiving medications had potential to be affected. This will be completed by 10/06/14. 3. The DON, ADON, Wing Managers and/or designees will monitor this process in random med pass observations weekly times 4 weeks then monthly for appropriate infection control while administering medications for other residents that could be Continued to page 5 of 5	

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F 441	Continued From page 4 hand, dropped the Potassium Chloride pill onto the top of the medication cart, picked it up with the bare fingers, placed it into the medication cup, and administered the medication to the resident. Further interview confirmed the medications were not administered using proper infection control.	F 441	Continued from page 4 of 5 affected. During random med pass observation, all Infection Control Procedures were followed appropriately, and no residents with potential to be affected were found to be affected with improper Infection Control Procedures. Annual in-services will be given to all Licensed Nurses and all new Licensed Nurses will be mentored and signed off as competent in appropriate infection control while administering medications. 4. The DON, ADON, Wing Managers and/or designees will monitor for this process in random med pass observations weekly times 4 weeks then monthly to ensure compliance, and in 90 Day Evaluations and Annual Evaluations. Appropriate infection control is reviewed in monthly QA Meetings. **October 06, 2014**	